



September 2, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via <https://www.regulations.gov/>

Re: File Code CMS-1770-P; Medicare Program; CY 2023 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 29, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the Heart Rhythm Society (HRS), this letter is sent to provide specific input on the CY2023 Medicare Physician Fee Schedule Final Rule regarding the proposed valuation for electrophysiology-based cardiac ablation services which are facing total reductions of nearly 40% effective on January 1, 2023. The significant cuts to the core family of ablation services would be devastating on their own, but CMS has chosen to implement them at a time when they could be exacerbated by an onslaught of other MPFS reductions. **HRS requests that CMS reconsider its decision regarding the work relative value units (wRVUs) discussed below. Specifically, we request that CMS revert the wRVUs for the services enumerated in this letter comparable to the values prior to the reductions effective January 1, 2022.** In this letter, we will detail rationale to support the reversal of these changes and ones made subsequently to further devalue these services. Comments regarding other important provisions in the rule will be provided in a separate comment letter.

The Heart Rhythm Society is the international leader in science, education and advocacy for cardiac arrhythmia professionals and patients, and the primary information resource on heart rhythm disorders. Its mission is to improve the care of patients by promoting research, education, and optimal health care policies and standards. HRS represents 7500 members in cardiac pacing and electrophysiology, consisting of physicians, scientists, and allied professionals. Electrophysiology is a distinct specialty of cardiology, with eligibility for board certification in both clinical cardiology and clinical cardiac electrophysiology through the American Board of Internal Medicine. In the U.S., HRS represents 3600 board certified electrophysiologists.



V. Valuation of Specific Codes [FR section II.E.]

B. Proposed Valuation of Specific Codes for CY 2023

(26) Cardiac Ablation Services Bundling (CPT codes 93653, 93654, 93655, 93656, 93657, 93613, 93621, 93662)

The key family of services are now represented by 93653, 93654, 93655, 93656 and 93657:

Code	Long Descriptor
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed
93655	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and His bundle recording, when performed
93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure)

In the CY2023 MPFS, CMS has proposed further reductions to cardiac ablation services that exceed the steep cuts resulting from the agency's actions in CY2022. In fact, the cuts go beyond the reductions that the AMA Specialty Society RUC recommended to CMS. There is no question that



these reductions will cause unintended and potentially devastating consequences for patients in need of these life-saving and life-enhancing services.

Exacerbating Disparities in Care

The impact of cardiac rhythm disorders such as atrial fibrillation (AF), disproportionately affect certain racial/ethnic minorities, particularly African Americans, Hispanics and Asians, as well as underserved rural and inner-city communities where health disparities already exist. A recent study showed that African American and Hispanic Medicare patients with AF have a higher unadjusted risk of death (46% and 11%) and stroke (66% and 21%) than White patients.¹ Further cuts such as what CMS is proposing, would exacerbate access to treatment and put patient's health at risk.

In January 2021, President Biden issued *Executive Order 13985, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*² to ensure patient access to the highest level of health care services regardless of ethnicity, disability, sexual orientation, gender identity, socioeconomic status or geography. To advance health equity, CMS recently outlined a strategy to close gaps in health care access, quality, and outcomes for underserved populations.³

HRS commends CMS on its efforts to eliminate health disparities among racial/ethnic minorities and socioeconomically disadvantaged populations, and in rural and remote areas. However, we caution CMS that drastic payment cuts from year-to-year run counter to the Administration's efforts to protect our nation's most vulnerable patients.

Exacerbating Shortages of Physicians Specializing in Electrophysiology

Another unintended consequence of the payment cuts is the impact on the field of electrophysiology (EP). In the U.S. there are less than 4000 physicians certified in EP, while the number of patients with AF is expected to double from 6 million to 12 million by 2030. Due to the high-intensity and risk of ablation procedures, an additional two-years of EP training is required on top of 10 years of medical training for cardiology and internal medicine. EP fellowships are already facing unfilled slots because of the time commitment needed to complete training. The steep payment reductions, if implemented, will present another barrier to meeting the growing demand for these cost-effective life-saving and life-enhancing procedures. A recent survey conducted by HRS in April before the second round of additional cuts was proposed shows that there is a potential threat to the quality and size of the electrophysiology workforce. Of 437 respondents, 345 (79%) engage in some amount of teaching trainees and staff. Of these, 195 (57%) indicated that they will be forced to spend less time teaching as a result of reimbursement changes. Only 66 (15%) reported that the cuts have not affected their career plans, while the majority (237 [54%]) reported a "significant" effect, including some considering alternate careers or earlier retirement.

The potential shortage of EPs could also lead to narrow provider plan networks, further compromising the availability of timely access to ablation services. This is especially concerning in rural areas where provider shortages are already a challenge.

¹ Tamirisa KP, Al-Khatib SM, Mohanty S, Han JK, Natale A, Gupta D, Russo AM, Al-Ahmad A, Gillis AM, Thomas KL. Racial and Ethnic Differences in the Management of Atrial Fibrillation. CJC Open. 2021 Sep 13;3(12 Suppl):S137-S148. doi: 10.1016/j.cjco.2021.09.004. PMID: 34993443; PMCID: PMC8712595.

² <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>

³ www.cms.gov/sites/default/files/2022-04/Health%20Equity%20Pillar%20Fact%20Sheet_1.pdf



We are concerned that CMS will not succeed in its efforts to advance health equity while inadvertently imposing access barriers to care at the same time. **HRS urges CMS to reconsider the reimbursement for these procedures in order to advance health equity and eliminate the downstream risks of the proposed payment cuts.**

Impact on Healthcare Spending

Ablation have procedures lead to significant reduction in hospitalizations and healthcare costs by decreasing the need for drugs, reducing disease and drug therapy related complications, lost wages and lost productive lives. While utilization of ablation services has increased, CMS must be cognizant of the cost to the healthcare system if these procedures were not performed. CMS should be supportive of high-quality ablation services and improving patient access to care to meet the incoming avalanche of arrhythmia patients in the next decade.

Overview of Recent Considerations

Due to changes in technology since these codes were first valued in 2011, increased utilization, and corresponding mapping and pacing codes frequently being billed together, the RUC recommended that CPT 93653 be referred to the CPT Editorial Panel for revision and bundling. At the October 2020 meeting, the CPT Panel agreed that the additional services should be bundled into 93656 due to the frequency of being billed together.

In December 2020, after receiving RUC survey data, neither HRS nor ACC were confident in the data. The societies presented the survey data at the January 2021 RUC meeting yet asked that the recommendations be considered interim and that the codes be re-surveyed for the April 2021 RUC meeting. The RUC agreed, and the societies took steps to ensure that those surveyed would better understand the new code descriptors. The RUC submitted a final recommendation for revised codes 93653-93657 for CY 2022 in May 2021.

Because the new values were provided to CMS after the deadline for CY 2022, the Agency proposed and finalized the existing CY2021 physician times and wRVUs for CPT codes 93653-93657, 93613, 93621 and 93662 for CY 2022. This action failed to account for the extensive revisions to include newly bundled work that was previously separately reported. In comments for CY2022, the AMA RUC, HRS and ACC indicated that it was not appropriate to maintain the current times and values for CPT codes that represented a different configuration of services than represented by the CPT codes in place in 2021.

As 93653 and 93656 have been extensively revised to newly bundle work that was previously separately reported, further reducing the values for these procedures fails to recognize the increased complexity, intensity and risk of these procedures and will unfairly and inappropriately reimburse electrophysiologists moving forward.

CMS Continues to Ignore Risk/Intensity/Skill of Complex Procedures

The actual ablation portion of these procedures is more intense relative to when this procedure was last valued in 2010. The cardiac electrophysiologist is now receiving much greater feedback from the catheter that is inside the beating heart (while the patient is breathing) and now knows exactly how many grams of force are being applied. When the base procedure was last reviewed, the physician would not have been certain that the tissue was contacted well enough to be delivering energy,



which resulted in the physician delivering repeated ablation on the same spots many times, to produce the necessary effect. The physician now knows exactly how well the catheter is contacting the tissue and is also examining the more impedance and various electrical measurements during the ablation delivery. This technology requires special expertise and tremendous concentration and monitoring.

Due to these recent improvements in technology, the induction of lesions is now more efficient and effective, but, also because of that, the risk of causing collateral injury during the ablation delivery is higher with each lesion delivery. For instance, the ablation treatment is much more intense in terms of risk of cardiac perforation, heart block and esophageal injury. Furthermore, while the physician is obtaining many more data points to create the 3-dimensional map, the physician still needs to make sure every one of those points is accurate as review of the data is not automated.

By adding further reductions for 2023, CMS is entirely dismissing the additional work entailed in these newly bundled services. CPT 93653 is typically the most intense service to perform among the three base codes in this family (93653, 93654 and 93656). CPT code 93653 is typically performed on a younger patient who does not have other conditions and the ablation site occurs very close to the patient's innate conduction system. Even under the best situation, there is a risk of causing heart block requiring a permanent pacemaker. The time during which the physician is applying radiofrequency energy is extraordinarily intense as opposed to the other two ablation services, 93654 and 93656, which are longer procedures on generally sicker patients, and the intensity is more spread out over time. The values approved by the RUC from the April 2021 meeting at least considered the intensity, complexity and risk of these services. The CMS proposed work values further undermine these services for 2023.

Flawed CMS Methodology

With its consideration of these ablation codes, CMS continues to rely on unjustified, flawed methodologies such as a sole focus on time ratios, reverse building block adjustments and incremental adjustments to arrive at its proposed values. This formulaic approach compounds the arbitrary nature of the proposed RVU, stripping it of relativity and leading to inconsistencies in the payment system. Additionally, in support of its valuation, CMS selected an arbitrary crosswalk, CPT 37229 Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed.

The two codes are not clinically related, nor do they carry the same level of risk and intensity. The CMS comparison of a much less risky and intense procedure in a lower extremity gives the appearance of seeking a derived value, rather than seeking a comparable valid, clinically relevant relationship that would preserve relativity. This is clearly evident by the fact that 37299 is performed overwhelmingly in the physician office setting. Cardiac ablation is always performed in the hospital setting and is excluded from the ambulatory surgical setting. CMS' formulaic approach compounds the arbitrariness of the proposed RVU, stripping it of mandated relativity that includes intensity/risk and leads to inconsistencies and unfair values in the payment system. As CMS continues to utilize an approach that ignores relativity that includes risk and intensity it is creating at its core, a flawed valuation system.



Further, CMS does not provide any clinical foundation for the comparison of the surveyed codes to the crosswalk codes and relies solely on time similarity. CMS' comparison codes often seem to have been selected solely for their similar work RVUs to the Agency's desired reduction and to justify similarly chosen time ratio comparisons. CMS ignores the clinical input from practicing physicians from valid surveys, rigorous review by HRS' and ACC's committee/Advisors and review of magnitude estimation and cross-specialty comparison that takes into account risk and intensity as conducted by the RUC.

When clinically compared, the code chosen by CMS versus what the majority of survey respondents chose are vastly different. The CMS comparator code 37229 describes vascular cannulation and access of a single arterial territory with routine balloon angioplasty (older technology) or stent placement for a static calcified lesion. The technical skill, intensity, and risks inherent in 37229 (a peripheral vascular procedure) cannot compare with those of arrhythmia ablation done inside the beating heart.

Once CMS applies its flawed logic to 93653, it simply uses it as the basis for adjusting the rest of the codes in this family with no regard to the work, intensity, or risk of the different procedures. Because the difference the RUC found between its wRVU of 15.00 for 93653 and 17.00 for 93656 is 2.0 wRVUs, CMS used that difference to adjust its arbitrarily lowered amount of 13.80 by 2.0 to come up with a work value of 15.80 for 93656. We believe this methodology has two critical flaws: 1) it wrongly assumes a fixed relationship in work/intensity/risk between 93653 and other ablation procedures and fails to evaluate the more complex 93654 and 93656 procedures on their own merits; 2) the flawed proposed wRVU for 93653 is carried forward to create flawed proposals for the other ablation services. Since CMS is unable to provide a clinical comparison, HRS includes a detailed discussion of code 93653 and 93656 below.

Codes 93653/93656

Code 93653 Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry

Code 93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/ recording, right ventricular pacing/ recording, and His bundle recording, when performed

Before even considering the bundled services, 93653 typically requires 4 separate femoral vein cannulations (unlike the single vascular access of the putative crosswalk procedure), direct access and manipulation of catheters into the beating heart, precise positioning of separate catheters to obtain electrical recordings from right atrial, His bundle, coronary sinus / left atrial, and right ventricular chambers; then a comprehensive electrophysiology study is performed to assess conduction properties of the various cardiac chambers and to induce tachycardia. During



tachycardia: pacing maneuvers are performed from the atria and ventricles, then 3D electroanatomic mapping is performed by manipulating the mapping catheter in the right atrium and left atrium to precisely localize the focus or reentrant mechanism of arrhythmia. Then, a series of radiofrequency or cryoablation “burns” or “freezes” to the heart are performed in order to block the abnormal conduction tissue responsible for the tachycardia. Finally, repeat electrophysiology study is performed to ensure that the tachycardia is no longer inducible and to assess for any unintended injury to the cardiac conduction system. If the tachycardia is still inducible, then repeat mapping and additional ablation is performed until the tachycardia focus is fully suppressed.

Besides the initial fact that cardiac SVT ablation (93653) requires more vascular access to start with (and therefore cumulatively greater risk of vascular injury and bleeding), the simple fact that the ablation procedure takes place in the heart introduces inherent risks of cardiac perforation leading to cardiac tamponade (a life-threatening complication), myocardial infarction, and stroke. The procedure is done in the beating heart and with the patient breathing (both introduce motion that is not seen in peripheral vascular procedures). Furthermore, one of the most common mechanisms of SVT is atrioventricular node reentry (AVNRT) in which the ablation target is close to the normal conduction tissue and there is significant risk of AV block (in which case the patient would need a permanent pacemaker for the rest of her/his life).

During ablation treatment to this type of critical area, the physician needs to hold the catheter tip within a 2-3mm area (again while the heart is beating and while the patient is breathing) – all the while monitoring multi-channel electrocardiogram recordings during every heart beat on one monitor and contact force, power delivery, tissue temperature, and impedance changes on another monitor for the duration of energy delivery. A delayed reaction of even 1-2 seconds could lead to permanent heart block or cardiac rupture. Other structures that could be injured during cardiac ablation include coronary arteries (causing myocardial infarction, shock, and death), esophagus (causing perforation, mediastinitis, sepsis, and death), phrenic nerve (causing diaphragmatic paralysis and long-term shortness of breath), and cardiac valvular injury (causing cardiogenic shock and need for emergency cardiac surgical repair). These facts make cardiac SVT ablation grossly different from 37229, and much closer to 93580, although we believe that even 93580 is not as intense or risky as 93653; it was the only reference code that more closely resembled 93653.

A newly bundled portion of 93653 and 93654 is the pacing described by 93621. The electrophysiologist must place a sheath into a central vein (i.e., internal jugular vein, subclavian vein, femoral vein) using percutaneous techniques. The physician then introduces a catheter into the sheath and advances into the right atrium, where the ostium of the coronary sinus is engaged, before advancing the catheter into the coronary sinus. The multielectrode catheter is used to record electrical activity from the left atrium and, at times, pace the left atrium to attempt arrhythmia induction. Repositioning the catheter as necessary occurs throughout the course of the procedure to optimize recordings and pacing thresholds. At the conclusion of the procedure, the catheter is removed, and hemostasis is attained.

Another newly bundled portion of 93653 and 93656 is 3-D mapping (93613). The electrophysiologist moves electrode catheters throughout each cardiac chamber in order to obtain location and electrogram information in a 3-dimensional map. This is done to create voltage and activation maps of each arrhythmia as the electrical impulse spreads through the heart, and to tag



areas treated by ablation. Although technological progress now allows higher resolution maps to be created, the electrophysiologist still needs to review for accuracy maps containing thousands of points – any of which could be incorrectly annotated by the automated system and thus mislead the diagnosis of arrhythmia location and mechanism. Multiple maps often need to be created for a single arrhythmia containing complex electrogram characteristics in order to achieve treatment success. Studies have shown increased ablation success and reduced and minimal fluoroscopy use (radiation exposure to patients and staff) in SVT and AF ablation procedures over time.

For the base code 93653 to justify a work value of 15.00 (25th percentile), the RUC compared the survey code to top key reference code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant* (work RVU = 17.97, intra-service time of 120 minutes, total time of 210 minutes) and noted that both services involve an identical amount of intra-service time and that 80 percent of the survey respondents who selected the top key reference code also indicated that the survey code 93653 is a more intense and complex procedure to perform. Therefore, we believe even the RUC-recommended wRVU (only an increase of .25 wRVU from the value CMS maintained for the base code in CY2022 despite the increased work that is now inherent with the newly bundled codes) does not adequately account for the intensity of 93653 as demonstrated in the surveys.

For 93656 (AF ablation), the additional work of transseptal puncture (using a needle to precisely puncture the interatrial septum to put 1-2 catheters into the left atrium) significantly increases the risk of cardiac perforation and tamponade. AF ablation is performed in patients who are fully anticoagulated. Not only is oral anticoagulation generally not held prior to the procedure, but high dose intravenous heparin anticoagulation is typically administered prior to and through transseptal puncture and left atrial mapping. Given the need for large central vein and transseptal puncture on full anticoagulation, the risk of the procedure is significant and requires much skill and additional use of vascular and intracardiac ultrasound to minimize the risk of cardiac perforation, tamponade and vascular injuries. Most, if not all, of the comparator procedures used by the RUC surveys are not performed on full anticoagulation. There is also an extensive area that needs to be treated with ablation (typically 80-150 spots around the pulmonary veins, that need to be precisely contiguous in order to create complete circumferential ablation to isolate the pulmonary veins). Each lesion needs to be full depth and yet not so much as to cause perforation or collateral injury (to the esophagus or phrenic nerve).

Again, this is done in the beating heart with respiratory motion where the operator needs to hold the catheter tip within a stable 2-3 mm space for each lesion. Due to the much higher number of ablation lesions delivered compared with SVT ablation, there is a cumulatively higher risk of esophageal injury (leading to esophageal perforation, fistula, and death) and phrenic nerve injury (leading to diaphragmatic paralysis and shortness of breath). Ablation in proximity to the pulmonary veins also induces risk of pulmonary vein stenosis (causing shortness of breath, pulmonary hypertension, and hemoptysis). The significant amount of time spent with catheters in the left atrium causes higher risk of thrombus formation on the catheters that could embolize and cause stroke.

Intracardiac echocardiography (ICE) (93613), now an integral part of CPT 93653, is used to provide high-resolution real-time visualization of cardiac structures as well as continuous monitoring of a



catheter location within the actively beating heart. It commonly guides transseptal puncture where the physician creates a hole in the septum of the heart to gain access to the cardiac chambers on the other side of the heart and is key for early recognition of procedural complications, such as pericardial effusion or thrombus formation. ICE remains highly technical in nature and requires the patient to be anesthetized. ICE is most frequently used with atrial fibrillation ablations, which is already a highly technical and challenging service. The intensity of the ablation is further compounded with ICE.

The base code 93656 was also revised to bundle the work of CPT codes 93613 (3-D mapping) and 93662 (intracardiac echocardiography during intervention, including imaging supervision and interpretation), which previously were separately reported add-on services. The recommended wRVU of 17.00 (again the 25th percentile of the survey recommendations), was compared to another related CPT code 93581 (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes). Both services involve an identical amount of intra-service time, whereas the reference code involves slightly more total time and is also slightly more intense to perform. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200, total time of 355) and noted that the reference code involves 20 more minutes of intra-service time and 92 more minutes of total time, justifying a lower valuation for the survey code. Again here, 93656 was inadequately valued due to limited comparator reference codes, and thus even the RUC-recommended wRVU does not adequately account for the intensity of 93656 as demonstrated in the surveys.

Code 93654

93654 Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording, and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and His bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed.

This procedure is performed on patients with ventricular tachycardia, who are the most complicated to treat, often with severe cardiomyopathy, advanced congestive heart failure, and recurrent heart failure admissions complicated by shocks from implanted defibrillators. These patients typically have already had an implantable defibrillator procedure. The defibrillator must be turned off prior to the procedure, and the patient requires more pre-service evaluation time to make sure that they are hemodynamically stable prior to and throughout the procedure. 93654 now includes bundled service of 93621 (left atrial recording and pacing) – described above – that increases the overall intensity of the procedure.

To justify a work value of 18.10, the RUC compared the survey code to CPT code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, intra-service time of 180 minutes, total time of 270 minutes) and noted that the survey code involves 20 more minutes of intra-service time and 21 more minutes of total time. The RUC also compared the survey code to CPT code 33978 *Removal of ventricular assist device; extracorporeal, biventricular* (work RVU= 25.00, intra-service time of 200 minutes, total time of 355 minutes) and noted that although both services involve an identical amount of intra-service time, it would be appropriate to value the survey code



somewhat lower due to the disparity in total time. The specialty noted, and the RUC concurred, that there are very few major surgical procedures that comprise 000-day or XXX global periods to use as reference codes to compare to the survey code. Again here, 93654 was inadequately valued due to limited comparator reference codes, and thus even the RUC-recommended wRVU does not adequately account for the intensity of 93654 as demonstrated in the surveys.

Add-on Codes 93655/93657

93655 Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure) and 93657 Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure).

The work of performing subsequent ablations which these add-on codes represent is the result of discovering while the patient is undergoing treatment that the patient has a more complex arrhythmia. When this occurs, it requires identifying further treatment areas and performing additional ablations to alleviate that arrhythmia.

The CMS proposed values were originally derived from inappropriate crosswalks last year and do not reflect the intensity of the work. The intensity increases when additional lesions are given. Additionally at this point in the procedure, there is a fatigue factor, ongoing anesthesia (and hence more risk), and increasing edema from the original ablation that make access to additional target sites more problematic. Mapping can become much more problematic, in addition to the fact that the left atrial catheter may have to be repositioned multiple times during the process. The same additional elements that were bundled into the base codes because they are now inherent to the ablation procedures—3D mapping, left atrial pacing, intracardiac echocardiography—are also performed during the respective add-on procedures. In the April 2021 survey, the survey data resulted in a 25th percentile of 7.00 work RVUs for 93655 and 93657. As stated above, the intensity of the work has increased due to the added bundled inherent in the base codes as well as the broader population of eligible patients. Patients who receive the add-on services typically are in a more complex disease state thus adding to the services' intensities. Consistently assigning RVUs to the 25th percentile raises questions about the appropriateness of using surveys to determine values.

Decreasing the values to 5.50 discounts the supported data of the two RUC surveys. Finally, the crosswalks recommended for the add on procedures are not clinically relevant. CMS again simply chose a service with identical service times because it has a lower work RVU, not because it appropriately approximates the skill, risk, intensity, and complexity of the work of performing additional ablation procedures by magnitude estimation. **The RUC-recommended values of 7.00 RVUs for CPT codes 93655 and 93657 were based on reference services that reflected a more appropriate level of risk/intensity. Choosing values from a previous survey where CMS rejected the rest of the corresponding values again points to a concerted effort to simply choose lower values.**

For practices and physicians managing practices in the current clinical and financial environment, the CMS logistics around how these services came to experience a significant payment reductions are irrelevant. The physicians providing these services will simply and



suddenly see a reduction from 21.73 work RVUs in CY2021 to 14.75 work RVUs in CY2022 and then even further to 13.80 in CY2023 if CMS finalizes its proposal for CPT 93653, a total reduction of over 35%. For CPT 93656, the reduction will be from 26.79 to 19.77 to 16.80 work RVUs, a total reduction of over 37%. Each of these reductions greatly exceeds 20% due to the further reductions that result from not recognizing the services that are now bundled into this procedure.

Conclusion

The reductions facing the physicians who provide cardiac ablation services are at odds with the Administrations' stated goals of advancing health equity, expanding access, and improving health outcomes while at the same time reducing health care costs where necessary. These dramatic reductions could negatively impact the care received by Medicare beneficiaries by accelerating shortages that are already being seen in electrophysiology training programs. For 2022, there were 60 unfilled training slots out of 371 for electrophysiology programs in the US. By increasing overall Medicare cost and disparities, as well as potentially decreasing the supply of these highly trained certified physicians who provide these valuable treatments, CMS is jeopardizing access for the Medicare patients who will need these very important lifesaving treatments in the future. **On behalf of our U.S. members, we implore CMS to reverse these reductions and restore the 2021 wRVU values.**

Sincerely,

A handwritten signature in black ink, appearing to read "AKrahn".

Andrew D. Krahn, MD, FHRS
President, Heart Rhythm Society